STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
-

Workforce Development Program

Family Provider Service Option Application

SECTION 1: Provider Information			
Legal Name:			
Date of Birth:	Telephone No.: ( )		
Physical Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Email Address:			

SECTION 2: Fees	
APPLICATION FOR FAMILY PROVIDER SERVICE OPTION (FPSO)	
Is this for a renewal? ☐ No ☐ Yes ☐ Family Provider Service Option (FPSO) Registration ($25.00)	$ 25.00
Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. Application fees are non-refundable. **Total Check/Money Order enclosed: =**	**$ 25.00**

Family Provider Service Option Definition: A Family Provider Service Option is a service provisions option that allows an adult, twenty-one (21) years or older, to register as a Personal Care Agency solely for the purpose of managing his or her own services or solely for managing the services of no more than two (2) of his/her family members. For purposes of this definition only, family members include individuals related by blood or marriage, as well as two (2) unmarried adults who are domiciled together under a long-term arrangement that evidences a commitment to remain responsible indefinitely for each other's welfare.

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Regulatory Services
Workforce Development Program
41 Anthony Ave
11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-5807 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: info.dhhs@maine.gov

Office Use Only:

Check# _____ *MO #* _____ *Amount $*_____ *Initials:* _____ *License#* _____

SECTION 3: Services

Please select the appropriate box:

☐ I manage my own services.

☐ I manage a family member's services:

1. Family member's name: _____ Relationship: _____
2. Family member's name: _____ Relationship: _____

Please indicate each type of health care or personal services that you provide or need:
(for example: bathing, dressing, shopping, cleaning, laundry, etc)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

SECTION 4: Declaration

- The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

_____ _____ _____

Print name of applicant **Signature of applicant** **Date**